Knighton Manor Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection focused on two different service types which operate from the same premises. The first being a residential care home, which is registered for the regulated activity 'accommodation for people who require nursing or personal care'. The second being a service offering support to people living within supported living accommodation, which is registered for the regulated activity 'personal care.' This inspection report has been written for both service types under the separate headings of care home and supported living.

The previous comprehensive inspection, which commenced on the 24 February 2015 found the service to be compliant with the regulations.

Care Home

The inspection of the service took place on the 23 and 24 February 2017 and was unannounced. Knighton Manor Limited provides residential care for 21 people with a learning disability and/or mental health disorder and a range of complex needs, which included physical disabilities and behaviour that challenges. At the time of our inspection there were 19 people in residence. The service provides accommodation over two floors, with access to the first floor being via a passenger lift and stairwells.

A registered manager was not in post. The manager facilitated the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager informed us they would submit an application to CQC to register as the manager.

We found there to be an open and collaborative approach between those using the service and staff. People's safety and well-being was promoted through the pro-active management of risk. This was achieved through the sharing of information and agreed strategies for promoting people's choices and in their day to day lives. Information was provided in a format which enabled people to understand the contents of information. There was a proactive approach in providing people using the service with the knowledge and information as to how they could report concerns about safety and well-being. This included policies and procedures which promoted safety.

People's medicine was managed safely and managed by staff who had received training. Audits were undertaken on a range of topics, which included medicines and maintenance of the environment to ensure people's safety was promoted and maintained.

We found people's safety, welfare and needs were met as there were sufficient staff employed, who had the relevant experience and training and were enthusiastic in providing a high level of care and support to people. Staff were regularly supervised and had their competence to perform aspects of their role assessed.

Communication between the management team and staff was open and enabled the proactive sharing of information which had a positive impact on people's lives.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice

People contributed to the development of meal choices with staff support. People's needs with regards to their diet were respected and supported, which included dietary requirements to support individual health needs. People were supported, where necessary, in the promotion of their health and welfare by attending routine and specialist appointments with health care professionals.

The manager and staff were committed to meeting the needs of people by encouraging people to share their views and opinions. People's care plans however did not reflect people's goals and aspirations, and the role of staff in providing the necessary support for these to be achieved. People took part in a range of activities within the service and within the wider community, which included visiting family and friends.

The registered person to ensure themselves of the quality of the service provided people using the service and their representatives with opportunities to comment on and influence the service being provided. People spoke positively and recorded their views about the staff and the staff's commitment to providing good quality care. The management team responded openly and positively where shortfalls were identified and worked collectively to bring about improvement.

We found a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report.

Supported Living

The inspection of the service took place on 27 February, 1 and 2 March 2017 and was announced. This meant the provider knew we would be carrying out an inspection. Knighton Manor Limited provides support to 20 people with a learning disability / and or mental health needs, and a range of complex needs, which included physical disabilities and behaviour that challenges. People resided within individual properties or within a complex of apartments, referred to as 'supported living'.

A registered manager was not in post. The manager facilitated the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's views and experiences about the quality of the service being provided were mixed. Representatives of young people, who had transferred to the services of Knighton Manor Limited from the parental home or residential college; and who required significant care and support, raised concerns about the quality of care and the safety of their relatives. They told us they had been provided with very limited written documentation about the services to be provided by Knighton Manor Limited. They informed us that a majority of information had been provided verbally. We found the lack of written documentation and formalised communication systems and opportunities for structured reviews of people's packages of care had contributed to people's representatives concerns. This had resulted in them having a lack of confidence in the provider and manager to deliver good quality care reflective of their expectations. Improvements to

people's safety and quality of care and support provided had been noted by people's representatives in recent weeks and they told us they were cautiously optimistic that continued improvements would be made.

People, who had been receiving support through adult services for some time and had transferred to the services of Knighton Manor Limited, moving into the supported living complex from the family home or a residential care home had in many instances had staff transfer with them. This had meant they continued to be supported by staff who knew them and who they were familiar with. People's records showed people were receiving the support they needed in safe way and by staff who had the appropriate skills and knowledge.

People's records and care plans did not clearly identify the services being commissioned and the hours allocated to ensure people's needs were met. This meant it was not apparent as to what support and care was being provided at any specified time, which meant people and their representatives were unsure as to the support being provided. The provider informed us upon people commencing with the service; commissioners in some instances had reviewed people's packages of care, which had resulted in the commissioned packages of care being reduced.

Staff we spoke with were knowledgeable about the people they supported and had a clear understanding as to their role in supporting people to maintain and increase their independence. Staff told us they had undertaken a range of training which provided them with guidance as to how to meet people's needs. Staff told us people's care plans were regularly reviewed and updated with information provided by the person themselves and through their own observations, to ensure people's needs were reflected.

Systems to enable the registered person to ensure themselves of the quality of the service being provided to people using the service and their representatives were not robust. We were saw a small number of questionnaires seeking people's views had been completed and returned. The provider and manager were aware improvements needed to be made through the provision of information and improved communication. The manager was working to the action plan put into place by commissioners to bring about improvements.

We found a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse because staff had an understanding of what abuse was and their responsibilities to act on concerns. Safe recruitment systems were followed to ensure staff were suitable to work with people who used the service.

Risk assessments identified the actions required by staff to promote people's safety and welfare.

There were sufficient numbers of staff within the care home who were available to keep people safe. People who received a service who resided within the supported living complex level had a package of care based on their individual assessment of need.

People received support with their medicine which was managed safely. The role and level of staff involvement in the support provided to people within the supported living accommodation with their medicine was not clearly documented or based on individual needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who had the appropriate knowledge and skills to provide care and who understood the needs of people. In some instances people upon accessing a service who resided within the supported living complex had been supported by staff that were not initially able to meet all their needs.

Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005. The legislation had been acted upon to ensure people's humans and legal rights were respected within the care home. People who resided within the supported living complex needs had not been clearly or sufficiently identified to ensure support was in their best interests for aspects of their care in order to

promote their rights, choices and independence.

People at risk of poor nutrition and hydration had assessments and plans of care in place for the promotion of their health and well-being. People's dietary requirements with regards to their preferences and needs were respected.

People's health and wellbeing was monitored. The role and level of staff involvement in the support provided to people within supported living complex was not sufficiently documented to reflect individual needs.

Is the service caring?

Good

The service was caring.

People we spoke with in the main were happy with the care and support they received and people's representatives within the supported living complex had noted improvements to their relatives care and support as a core group of staff were now involved in providing care and support.

People and their representatives were involved in the development and reviewing of plans of care.

People were supported by staff who were committed understood their role in the promotion of people's rights and who listened to and respected people, in order that their privacy and dignity was promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed prior to receiving a service, and involved the person and their representatives. People's initial assessments who resided within the supported living complex did not fully reflect people's need and recognise the promotion of their independence and choice, which meant the role and responsibilities in the provision of their care and support, was unclear.

People were encouraged to maintain contact with family and friends and were supported to access resources within the wider community.

People had a range of opportunities to raise concerns and their rights to raise concerns was emphasised. People using the services and their representatives who resided with the

supported living complex were not familiar with the complaints policy and procedure, which meant concerns raised had not been consistently managed and responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A registered manager was not in post. The management structure of the care home enabled and encouraged open communication and dialogue with those that used the service and their representatives. This brought about continuous improvements in the quality of care people received. There was a lack of information and effective and consistent systems for communication for those accessing the service that resided within the supported living complex. This had impacted on the confidence of people in the leadership of the service and their ability to provide good quality care and support.

Knighton Manor Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Care Home

The inspection took place on 23 and 24 February 2017 and was unannounced. The inspection was carried out by an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in people with a learning disability.

We spoke with five people and spent time with others who used the service. The information people were able to provide was limited due to their disability. We spoke with the registered person, the manager, and the deputy managers and four support workers.

We contacted commissioners for social care, responsible for funding people that live at the service and asked them for their views about the service.

We reviewed the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that providers must tell us about.

We looked at the care plans and records, including medicine records of three people. We looked at the recruitment records of three staff. We looked at staff training records and minutes of meetings for staff. We viewed records in relation to the maintenance of the environment and equipment along with quality monitoring audits.

Supported Living

The inspection took place on 27 February, 1 and 2 March 2017 and was announced. The inspection was

carried out by an inspector. We told the registered person we would be carrying out an inspection. We gave them notice to enable them to speak with people who use the service and their family members to ask them if wished to meet and speak with us in their homes.

We spoke with and spent time with six people who used the service. We spoke with the parents of three people using the service. The information people were able to provide was limited due to their disability. We spoke with the registered person, the manager, the deputy manager and one support worker and two care assistants.

We contacted commissioners for social care, responsible for funding people that live at the service and asked them for their views about the service.

We reviewed the information we held about the service, which included 'notifications'. Notifications are changes, events or incidents that providers must tell us about.

We looked at the care plans and records, including medicine records of three people. We looked at the recruitment records of three staff. We looked at staff training records and minutes of meetings for staff. We viewed records in relation to the maintenance of the environment and quality monitoring audits.

Good

Is the service safe?

Our findings

Care Home

We asked people if they felt safe. One person told us, "Yes." Whilst a second person replied. "Yes, it's a nice place. The doors are locked at night." We asked people what they would do if they saw something that they were not happy with. One person said, "I'd tell the office (managerial staff) or [named member of staff], there is a meeting if you want to go to, you can go and tell them (staff) everything is alright, it's alright at night." We asked people if anyone was bossy and they told us, "No, I'd tell the staff if there was."

We asked staff what action they would take if they believed someone was experiencing abuse or avoidable harm. A staff member told us about whistleblowing. "I know about it, I would approach management who are very responsive but I would whistle blow if needed." This meant staff were aware that they could report concerns to other agencies if they had concerns, further promoting people's safety and well-being.

The provider, manager and staff alerted the relevant agencies when potential safeguarding concerns were identified and worked with other agencies to ensure people were protected from abuse and avoidable harm.

A member of staff told us when asked about the promotion of people's safety. "I think it's safe here, there are policies and procedures, there is good communication, residents meetings and we highlight that they can talk to the staff."

The provider and staff used a range of ways to raise people's awareness of safety to promote their safety and well-being. Meetings for those using the service were held monthly. Meetings were used as an opportunity to explore with people using the service if they felt safe and what being safe meant. The minutes recorded people felt safe and were confident to speak with staff about any issues of concern.

Policies and procedures for the promotion of people's safety were in place, which included information about advocacy services, a policy on safeguarding people from abuse, a fire policy and procedure, which included individual risk assessments for the evacuation of the service in an emergency, known as PEEP's (personal emergency evacuation plan).
Staff spoken with were knowledgeable about promoting people's safety and told us that where risks were identified action was taken to reduce the risk. A member of staff said, "There are risk assessments in the care plan, new ones are identified and written up for example a resident slipped off their bed. There was a risk assessment to prevent it happening again, the family were made aware, and the risk assessment was shared with the family."

People's records included risk assessments, which identified potential risk and the measures to reduce the risk. Risk assessments were regularly reviewed to ensure they contained up to date and accurate information. The manager and staff we spoke with had a good understanding as to the needs of people and how to support them, which recognised the need to promote people's safety with consideration to their

rights and choices. For example, one person enjoyed making themselves a hot drink, to reduce the risk of scalding the person used equipment which enabled them to make an individual hot drink safely. People's safety was promoted when accessing the wider community. People were supported by staff to access services independently where practicable, which in some instances meant people taking with them a 'card', which had the address and the services telephone number, which could be used in an emergency.

Policies and procedures were in place where the provider had involvement with people's finances. Records were kept as to people's individual expenditure which included the receipts for items purchased and financial records signed by the two members of staff involved. Records we looked at showed that people had an appointee responsible for their financial affairs that were independent and not employed by the provider. The provider had a system for auditing people's monies and records this helped to safeguard people from potential financial abuse.

There were effective systems in place for the maintenance of the building and its equipment and records confirmed this, which meant people were accommodated in a well maintained building with equipment that was checked for its safety.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for staff. Staff recruited by the provider underwent a robust recruitment and interview process to minimise risks to people's safety and welfare. Prior to being employed, all new staff had an enhanced Disclosure and Barring Service (DBS) check, two valid references and health screening. (A DBS is carried out on an individual to find out if they have a criminal record which may impact on the safety of those using the service).

We found there were sufficient staff on duty to meet people's needs and keep them safe. The manager told us that staffing numbers were increased when people required additional support with their day to day lives, which included accessing the community for health care appointments and attending leisure activities. For some people using the service, additional funding had been made available by commissioners to provide one to one support for specific aspects of their care. The staff rota identified the staff responsible for providing the one to one support and care along with additional staff where activities within the wider community were taking place, for example a trip to the theatre. This showed the service had a flexible approach to staff enabling them to promote people's safety and meet their needs.

We looked at the medication and medication records of three people who used the service and found that their medication had been stored and administered safely. This meant people's health was supported by the safe administration of medication. People's plans of care included information about the medication they were prescribed which included protocols for the use of PRN medication (medication, which is to be taken as and when required). This ensured people received medication consistently. Staff had received training reflective of people's individual needs. For example, where PRN medicine was to be administered to promote people's health and welfare, such as the administration of medicine when people experienced an epileptic seizure.

We found people's medicine which was no longer required due to changes in the person's needs was kept within a lockable cupboard, awaiting its return to the supplying pharmacist. However there was no record as to the contents of the cupboard to ensure medicine was being managed safely. The deputy manager took immediate action by undertaking an audit of the medicine awaiting return to the pharmacist. The following day we were advised the medicine had been returned to the pharmacist and the policy and procedure had been updated to reflect all medicines stored within the cupboard awaiting return would in the future be recorded.

Supported Living

Staff were trained in safeguarding as part of their induction so they knew how to protect people from abuse and avoidable harm. When we spoke with staff about the safeguarding procedure they were knowledgeable about their role and responsibilities in raising concerns with the management team and the role of external agencies. This meant people using the service could be confident that the welfare and safety of people was understood by staff.

Policies and procedures were in place where the provider had involvement with people's finances. Records were kept as to people's individual expenditure which included the receipts for items purchased and financial records signed. In some instances people's money was kept within the office based within the supported living complex, and we saw that people upon requesting their money signed to say they had received it. This meant people's money was safely stored and that people had access to their money when requested.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for staff. Staff recruited by the provider underwent a robust recruitment and interview process to minimise risks to people's safety and welfare. Prior to being employed, all new staff had an enhanced Disclosure and Barring Service (DBS) check, two valid references and health screening. (A DBS is carried out on an individual to find out if they have a criminal record which may impact on the safety of those using the service).

People's records included risk assessments, which identified potential risk and the measures to reduce the risk. The manager and staff we spoke with had a good understanding as to the needs of people and how to support them, which recognised the need to promote people's safety with consideration to their rights and choices. For example, one person had been identified at potential risk as they accessed the wider community independently. Systems had been put into place to promote their safety by the use of a mobile telephone, which could be tracked and used to locate the person if they had not returned to the supported living complex at the time they had indicated.

People's assessments in some instances had identified that they required continuous support to keep them safe. This service was a commissioned serviced which meant the provider employed staff to support people on a continuous basis, which meant during the night staff slept within a dedicated room of the person's home to promote their safety and welfare. In addition 24 hour support was provided within the apartment complex, which people could access in an emergency.

The provider employed 48 members of staff, who were provided with a rota which identified the people they were to support. People's representatives informed us that when their relatives initially accessed the service they were not supported by a core group of staff and staff in many instances did not have the knowledge and skills to meet their relative's needs. We were told that they themselves had provided information and instruction to staff to ensure that their relative's needs were met safely. A family representative informed us how their relative required equipment to maintain their safety and health and that they had upon visiting their relative found the equipment was not being used or not be used correctly. They went onto say that this had put their relative's safety and health at risk and had resulted in them losing confidence with the service being provided. They told us the equipment was now being used to ensure the person's safety as staff were aware of how it was to be used and why.

People's representatives informed us that medicine errors had occurred when their relative commenced with the services of Knighton Manor Limited, however improvements had now been made. They told us medicine had not been administered and in some instances the incorrect dose had been given. People's

care plans provided information as to the medicine people were prescribed, which included protocols for PRN medicine and the support people needed, for example prompting. Staff signed medication administration records (MAR) when medicine was administered.

The manager confirmed that medicine errors had occurred and that action had been taken to bring about improvement. This had included additional training for staff on the safe management of medicine, staff we spoke with confirmed they had received training in medicine management. The manager had secured the services of a pharmacist who provided people's medicine and delivered it to the office that was located within the supported living apartment complex, and was then distributed to people's apartments, for staff or themselves to administer.

Requires Improvement

Is the service effective?

Our findings

Care Home

We spoke with staff who told us about their induction when they commenced working at the service. They said it had included working alongside experienced staff, becoming aware of the provider's policies and procedures and reading the plans of care for people. A member of staff told us, "As part of induction I visited (a person using the service), did a shadow shift, and training." Another member of staff commented, "Every new member of staff is introduced to residents and we go through care plans."

A programme of induction, which included training, was in place. Staff new to the field of caring for people were enrolled to undertake The Care Certificate. This is a set of standards for staff that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support.

The provider was committed to staff development and training, and had a programme of training in place for staff. Records showed staff had received training in a range of topics to support the health, safety and well-being of people, which included attaining qualifications in health and social care. The manager provided us with records that showed there was a programme of training for all staff, this included ancillary staff. The manager told us all staff were included as they often had as much contact with people who used the service as care staff and so needed to understand what care should be provided to people. This showed a commitment by the provider to deliver and provide high quality care through staff training.

Staff were regularly supervised and had an annual appraisal with a member of the management team. Staff had their competency to provide care and support assessed by a member of the management team in a range of topics, to ensure the care and support people received was of a good quality and reflective of staff training and the policy and procedures of the provider.

We observed good communication between staff and the management team throughout our inspection. The manager had an open door policy, which meant staff sought the advice and guidance of members of the management team when required. Effective communication ensured that people received their care and support in a timely manner as staff approach to people's care was clearly understood by all, with specific tasks being allocated to named staff.

Regular staff meetings took place, which provided an opportunity for the management team and staff to share information, enabling them to provide an effective service to meet people's needs. A staff meeting took place during the inspection and we heard first-hand how good communication supported the day to day management of the service in meeting people's needs. For example, staff were asked to record comprehensively a specific aspect of a person's care. This was to ensure health care professionals had access to information to enable them to make any changes or recommendations as to how a person's care was delivered.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found ten people had a DoLS authorisation in place, of which some had conditions attached. We found the conditions were being met by the provider, which required the recording of incidents where people's behaviour was challenging, accessing the wider community for recreational activities and support with maintaining relationships with relatives.

The records we looked at where people had a DoLS in place recorded the involvement of a 'paid person's representative' (PPR). The PPR's role was to monitor the implementation of the DoLS and as part of their role they spoke with staff and viewed the person's records which recorded how staff implemented the DoLS. We spoke with a PPR who was at Knighton Manor Ltd to meet with a number of people and view their records. They told us they regularly spoke with the manager and other staff in connection with people's DoLS and found them to be knowledgeable and supportive of people's needs and their role and responsibility regarding the promotion of people's rights and choices.

In some instances people had made an advanced decision about their care with regards to emergency treatment and resuscitation, which meant they had a DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) in place. This had been put into place with the involvement of the person, their relative or representative and health care professionals. This showed that people's choices and decisions were supported and would be acted upon when needed as agreed by all parties involved.

The menu for the day was on the wall in the dining room, with supporting pictures to assist people in understanding the choices available to them. People were also asked or shown the meal options available to them, which included drinks. We asked people for their views about the meals, one person told us, "beautiful." And, "They are big meals, there is enough to eat, they ask if you want any more, you don't have to have it if you don't like it. There is supper you can also have if you want to go down (downstairs) for. I've got tea and coffee maker in my room."

Meetings for those using the service were held monthly. Meetings were used as an opportunity to explore with people using the service their views about the meals being provided. The minutes of a recent meeting had recorded people had requested a wider range of puddings to be made available, and subsequent minutes showed this had been acted upon. The minutes recorded people's enjoyment of the 'takeaway' night, held once a month with people wanting to try a wider range of cuisines from around the world. A request was made for more chocolate, and the minutes recorded this had been added to the shopping list.

At lunchtime a majority of people ate their meal in the dining room, over two separate sittings. This enabled people who required additional support to eat their meal separately, with sufficient staff to provide support. The calm and relaxed environment, supported people's concentration in eating, thus reducing the risk of their choking

People's record we looked at included a nutritional assessment which had identified where people were at risk of choking. A Speech and Language Therapists (SALT) had been contacted who had assessed people's needs and had provided a care plan for the staff to follow. Care plans reflected the support people required, which included guidance on the texture of people's food, along with the prescribing of nutritional supplements, this ensured people's dietary needs were met to promote their health. At the team meeting staff were reminded to fully record how people's food was fortified, for example by the use of cream or butter, to ensure people's dietary needs were fully monitored and recorded.

People's records and leaflets stored in the office contained information about specific health care related conditions, such as epilepsy, bi-polar disorder and dysphagia and could be accessed by staff. The information provided staff with an insight and awareness on how specific health issues affected people's health and welfare. For example, the information about bi-polar stated how this affected a person's mental health on a day to day basis. This information had been used to develop the person's care plan, which provided guidance for staff on how to respond and support the person by understanding how the person's behaviour could be interpreted to inform staff as to the person's well-being.

Each person had a 'health action plan', which held information about people's health needs, the professionals involved in their support, along with a record of appointments attended for the promotion of their health and well-being. Information about people's medicine, their likes and dislikes along with communication needs, for example, which included how a person expressed they were in pain, were also documented. A quick reference 'accident and emergency grab sheet' was in place that contained essential information to be shared for the benefit of the person should they have to access health care services in an emergency.

Records showed people had timely access to a range of health care professionals, which included doctors, chiropodists, opticians, dentists and dieticians. Specialist services such as diabetic health screening also supported people within the service in the assessment and development of plans to enable staff to provide good and safe care. Records showed people were supported to attend routine screening appointment, which included screening for a range of cancers.

Where health care professions had identified concerns, action was taken to support the person in the maintenance of their health. For example one person had recently been prescribed spectacles; a gradual plan of introducing the person to their spectacles had been put into place by staff.

Supported Living

We spoke with staff who told us about their induction when they commenced working at the service. They said it had included working alongside experienced staff, reading the provider's policies and procedures and the plans of care for people. A member of staff told us, "I shadowed experienced staff for a couple of weeks and the manager observed me supporting people to access my competence." A second member of staff who had transferred their employment when a person moved to receiving a service from Knighton Manor Limited, told us. "I moved with [person's name], so I already knew them. However I have spent time getting to know other people and I now regularly support three people."

People's representatives spoke about the concerns they had when their relative first started using the services of Knighton Manor Limited. They told us that their relative was initially supported by a number of staff and not a core group of staff to enable positive professional relationships to be developed. They informed us that they or their relative had not been involved in staff recruitment to determine whether the applicant would be potentially compatible, in order that the person's care and support was provided

effectively. People's representatives said improvements had been made in that a core group of staff now supported and cared for their relatives. This meant staff had a greater understanding of people's needs and people's relatives received support and care based on staff's increased understanding of the person. People's representatives told us that since their relative had been supported by a consistent group of staff the quality of the care and support they received had improved.

People's representatives told us they had been assured that upon commencing with the service; staff would be able to meet their relative's needs as staff had the knowledge and experience required. We were given examples of where people's experiences had not reflected this. They told us that they had had to provide training and guidance on specific aspects of their relative's care in order that their needs were met safely and effectively by staff. For example, a representative told us that their relative's assessment had identified that they displayed behaviour that challenged. The person's representative informed us that staff struggled to provide the appropriate support, which meant their relative became highly agitated at times as staff were not equipped to support them appropriately. The person's representative told us that staff awareness of their relatives needs was now more fully understood by staff.

Staff knew to the field of caring for people were enrolled to undertake The Care Certificate, which is a set of standards for staff that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support. Staff spoken with confirmed they had received a range of training, some training being specific to meet people's individual needs. For example in the administration of medicine to be used in an emergency when someone had an epileptic seizure.

Staff were supervised, however the manager acknowledged supervisions did not take place as often as they would like them to be, and that a programme for supervisions for the year was being put into place. The manager told us this was a result of their spending time to bring about improvements to the quality of the service being provided.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. We found where decisions had been made by the Court of Protection these were understood and adhered too.

We found people's assessments of their needs had not taken into consideration their capacity to make informed decisions about key aspects of their care. This meant staff, under the instruction of the provider and manager, had in some circumstances taken on the responsibility for these. For example the management of people's medicine; and for some people this also meant support with the safe keeping of people's money. We spoke with the provider, manager and deputy manager who told us they would take action. They told us they would ensure that changes would be made to ensure people's support and care was reflective of the principles of the MCA and their assessed needs. They told us any decisions made would be made in the person's best interest and documented and that decisions arrived at would involve of the relevant people.

People's care plans included information about their dietary requirements, which included their likes and

dislikes. Staff from the service supported people in undertaking shopping for groceries, and the preparation and cooking of meals. We heard staff encouraging people to undertake grocery shopping and speaking with them as to its importance to ensure they had food to eat. Staff recorded what people ate, which included where food was offered but declined.

A person's representative informed us that when their relative had started using the service they had been underweight, and that staff had worked well with them to improve the person's weight. Their relative's weight was regularly monitored, and staff worked well with them using distraction techniques which were necessary to encourage the person to eat. They went onto say staff included blended nutrients within their food to promote a health weight gain.

People's representatives raised concerns that staff in some instances did not have basic cooking skills and that they had had to teach staff how to cook meals, which their relative enjoyed so that their relative was not reliant on pre-packaged meals. A second family representative informed us that they bought groceries for their relative, however they had had to raise concerns that fresh food produce was not used timely, which meant it was then inedible and had to be thrown away. We were also informed that staff accessed local shops to purchase groceries, which were more expensive as there were insufficient drivers to enable their relative to be taken further afield for grocery shopping. The manager informed us a limited number of staff were able to drive people's vehicles, however recognised that the lack of drivers did impact on people's support and care, where they had complex needs, in accessing the wider community as they were unable to access public transport. The manager told us they hoped to recruit additional staff who were able to drive.

People's care plans provided information about the range of health care professionals involved in their care. The manager informed us that where appropriate staff supported people to attend medical appointments.

A person's representative spoke positively as to how staff had managed an emergency situation to promote their relative's health and welfare. They informed us their relative had had a seizure and staff had acted swiftly in contacting emergency services to provide the necessary support. They told us staff had followed the instructions given by the staff of the emergency centre until the ambulance arrived.

We found there was lack of written information and clarity about the role and responsibilities of provider, manager and staff when people transferred their care to Knighton Manor Limited. This for some people had meant referrals to specialist services to ensure people continued to receive support was not managed effectively. People's representatives told us that health care referrals to specialist services were not made timely by Knighton Manor Limited. They told us they had in some instances made the referrals to specialist services themselves to ensure their relative received the health care support they needed. The lack of documentation around people's transfer arrangements to the service meant there was a lack of written information to outline the responsibilities of Knighton Manor Limited, in these arrangements.

Good

Is the service caring?

Our findings

Care Home

People were supported by staff that had worked at the service for a long time, which meant staff knew people well and had built up and developed positive relationships. We asked people if staff were kind and caring and people told us "Yes." One person when asked if staff knew the residents well replied "Yes." "We observed people being supported by staff throughout our inspection and saw people being supported in a caring manner. We noted positive relationships between people and staff which included laughter and conversation as well as the provision of support for people in attending appointments and accessing recreational activities.

We asked the PPR who was visiting for their views as to the care and support people received and the attitude and approach of staff. They told us staff had good relationships with people and supported them in maintaining their independence. They went onto say that staff responded positively to people, which had made a positive impact on people's lives. For example, they told us how staff had identified that a person, whose behaviour at times could be challenging, had noted listening to a specific radio channel helped the person to become calm. This showed how staff's knowledge and understanding of people was used positively to improve people's lives. The PPR also stated that the quality of care people received was also in part due to a consistent group of staff working at the service.

Staff told us contact with people's relatives and friends was promoted. This included relatives visiting the service and people from the service going to their relatives' homes, in some instances supported by staff. People were also supported to develop relationships with people to meet their social needs, with staff support where required.

People's records contained information about their lives prior to moving into the service, which included information about their relatives and friends, as well as information as to their hobbies and interests. This information was used to develop care plans to support people's likes and dislikes, for example a person who attended Church with a friend, continued to do so to maintain the previous link of friendship. Whilst other people's hobbies and interests for example taking part in board games was an activity they were encouraged to maintain.

We asked staff how people were supported to express their views about the care and support they received. A member of staff told us three people had an advocate. We asked them to tell us about the impact on a person of having an advocate. They told us that one advocate was working with occupational therapists and speech and language therapists to undertake a sensory assessment. The purpose was to provide a one to one plan of care specific to the person's needs. The person's records confirmed the information provided by the member of staff, which had been considered under the MCA and a best interest decision had been agreed upon for the sensory assessment to be undertaken. This showed people's rights were supported when they themselves were unable to express their views.

People's plans of care were person centred in that they were specific to the person's needs and in some instances signed by the person. People's care plans provided clear guidance for staff as to the views of people and how they wished their care to be provided. For example, one person's plan detailed that they didn't like a break in their daily routine, and provided staff with information as to how to maintain the person's structured routine. Whilst staff supported people in achieving their personal goals and aspirations, these were not fully reflected within people's care plans, and how success and achievement was to be measured and monitored. Nor was the role of staff in supporting people in these clearly documented. The manager told us they would ensure people's goals and aspirations and the role of staff were more fully recorded.

People's records contained a 'communication passport' which described how staff were to communicate with them well. For example, staff were to approach a person with a visual impairment from the front and consider the tone of their voice when speaking with the person. Whilst other people's communication passports, contained information as to how they expressed their emotions, for example, when in pain or happy. The documents also included how people responded to external changes in the environment, such as sound and smells. This enabled staff to respond to people in a way which supported their individual needs.

A person living at the service asked us if they could show us their room. They told us, "I've got my own key; some people have their own keys so long as they don't lose them". The person introduced us to the cat that was sleeping on the first floor landing. The person said, "We have a cat, it lives here." We went into their room, and they showed us a birthday card. They asked for us to open the card, the birthday card was from the people who they shared the service with, and read 'love from all your friends at Knighton Manor.'

People's bedrooms were respected as their own space and the décor and furnishing reflected their individual tastes and interests. We noted staff did not enter a person's bedroom until they had knocked on the door and introduced themselves.

Information was made available to people using the service in large print, using easy read words supported by symbols and pictures to assist people in their understanding. Key policies and procedures, signs for specific rooms, such as bathroom and toilets had been developed in this format. Along with the minutes of meetings, menus and care plans.

Supported Living

The manager and staff had liaised and worked alongside staff already involved with people's care and support. This had helped to provide a smooth transfer from the person's current service to that of Knighton Manor Limited and their move into the supported living complex. People's records showed they had visited with support, the accommodation and been introduced to staff who worked within the supported living complex. We noted that a significant number of staff had transferred their employment to Knighton Manor Limited, which meant people had continued to receive care and support from people they knew and therefore received a continuation of the care and support they were familiar and comfortable with.

People's care plans included information as to how they communicated. They contained information that enabled staff to provide support. For example, one person's care plan stated that the person understood two languages and that in some instances the person chose not to communicate with people they were unfamiliar with. The care plan identified the importance of how staff phrased questions put to the person by highlighting that the person would repeatedly ask the same question if they were anxious. When we spoke with staff who supported the person, they had a good understanding of the person's needs, and were able

to tell us how the information within their care plan enabled them to be sensitive when providing support to the person, which included when they accessed the wider community to ensure they did not become anxious and distressed when taking part in activities involving other people.

People's privacy and dignity was respected by staff who understood that they were supporting people within their own homes. We asked staff how they promoted people's privacy and dignity. They told us, "My role is to help people, not to do things for them, any assistance I provide is based on their needs and I offer encouragement, this helps people to maintain their privacy and dignity."

Requires Improvement

Is the service responsive?

Our findings

Care Home

We asked people if they made choices about their day to day lives. One person told us, "I go to town, walk around town and go to Centre Parcs." People's views about activities and social events were discussed at meetings, with people being encouraged to share their views and put forward ideas. We saw these were acted upon, for example. The minutes of a meeting highlighted people wanted the opportunity to attend a pantomime over the Christmas period, whilst others spoke of day trips, which included the circus and going to the theatre. People's records showed people had attended a range of activities with further activities for the forthcoming year being planned for, which included a holiday.

As part of our inspection we saw that people were involved in a range of activities, which included going out to access the wider community as well as taking part in activities within the service. Staff spent time with people encouraging them in arts and crafts, playing board games, dominoes and completing jigsaws. In the morning we saw that staff were not always pro-active in their interaction with people with complex needs (limited physical movement and ability to communicate) and opportunities to engage with people were sometimes missed. For example, we noted a person appeared to become anxious, looking around the room when someone else became quite loud. Whilst a member of staff supported the person making the noise, staff did not appear to notice the reaction of the other person to the noise. After lunch we saw positive interactions with people with complex needs, a member of staff came into the lounge and spoke with someone in a very animated and friendly way. The person appeared to 'light up', reach out for their hands and their eyes followed the staff member. We spoke with the manager about our observations, who confirmed that staff had been spoken with about the importance of interacting with people who had complex needs.

Our observations of staff not always engaging with or understanding people's involvement with activities who had complex needs was reflected in how they wrote about people's social interactions with general comments and statements. For example, 'the person sat relaxing to music, or watching television.' There was no information as to whether the person enjoyed the activity or many examples of people being supported to take part in other activities, to stimulate their senses, such as water play or accessing the wider community. We spoke with the manager as to how staff encouraged people with very limited or no verbal skills, with limited physical movement and abilities to take part in activities, as we noted staff did not spend much time with them. They informed us sensory equipment was available; sometimes this was kept in people's bedrooms. Upon returning to the service over subsequent days, we found sensory equipment to be in the lounge and one person sat watching a fibre optic display of colour and water.

People's views about specific aspects of their care were being sought, which included their wishes with regards to their death. People, their relatives or those acting on their behalf had been contacted and asked to provide information. The manager told us that some relatives and legal appointees had responded, and had provided information, which included information as to funeral arrangements. The information gathered was being used to update people's care plans to ensure their needs and wishes were understood.

The manager and staff supported people to maintain relationships with their relatives and friends, in addition to people seeing each other in person, staff ensured people sent their relatives and friends cards to signify special events such as birthdays. One person's relative was sent a personalised newsletter, which provided them with information such events and activities they had taken part in. The newsletter contained a personal message from them to their relative. We found the person's relative had written to staff to thank them for spending time and providing support to enable them the person to write the personalised message.

People's concerns and complaints were recorded by the manager, along with the action taken as a result of complaints or concerns. We found concerns were used to further develop the service. For example, the CQC received information of concern about named people who used the service. A safeguarding alert was made to the local authority. Representatives of the local authority visited the service to meet with people, speak with staff and view records. Whilst the investigation found no evidence to support the concerns, the manager organised additional team meetings and individual supervisions to discuss and share with staff the issues raised, to ensure continued learning by staff. The team meeting which took place during the inspection was used to remind staff to record the time of their care interventions, for example what time people got up, or went to bed. This was as a result of feedback gained as part of the investigation carried out and used as lessons learnt to improve practices.

Supported Living

People who had moved into the supported living accommodation had their needs assessed by a commissioner, who had referred them or their representative to the provider. We were told a manager of the service had undertaken their own assessment to identify whether the person's needs could be met, however these were not sufficiently robust to ensure people's needs were identified as they did not provide information as to people's aspirations and goals and their expectations of the service. This meant the provider and manager were unable to put into place the appropriate support through planning to ensure people's needs were always met. The manager informed us that they were in the process of reviewing the assessment process for people, to ensure people's views were reflected.

The representatives of some people, who had complex needs, shared their concerns with us as to how the service being provided did not meet their expectations. They told us the services that had been discussed with them as part of the assessment process and introduction to the service had not been provided in full. They told us how this had impacted on the care and support provided. For example, some people had their own car; however there were insufficient staff that were able to drive, which meant people's access to the wider community had been restricted. Whilst others told us they had been assured of a policy of social inclusion and stimulation through the provision of day care which would be operated on site. People's representatives told us this was at an additional cost, however in their view the services provided through the day care facility had not lived up to their expectations. We shared people's comments about their expectations having not been met on a range of issues with the provider and manager, who acknowledged that people's move into the service and accommodation for some could have been a more positive experience for all involved. The provider and manager spoke of their commitment to bring about improvement, through improvement communication and consultation with people using the service and their relatives.

We found some people had received a responsive service when they had moved into the supported living accommodation, which had been tailored to meet their individual needs. For example one person supported by their social worker had moved into the supported living complex and was receiving the support they needed to manage their day to day affairs. We saw and heard staff supporting them in

contacting a range of services in relation to their financial affairs and the planning of the installation of utilities, which included a telephone line to be installed into their apartment so that they could use the internet.

People's representatives informed us improvements had been noted in recent weeks, which had included a core group of staff supporting their relatives and who were encouraging their independence. One person told us, "I have seen staff support [person's name] by encouraging them to put their washing away. The staff member walked into the bedroom, and gave [person's name] the coat hangers to help put onto the clothes." "They're very happy and settled. [Person's name] is eating better; they've been monitoring their weight." And, [Person's name] has blossomed, the open plan living has improved their interest in what's going on around them and they have now started to stand up to move to the dining table in anticipation. They're going outside and walking."

We found complaints and concerns had been made by the representatives of people who used the service, in some instances they had shared their views with their relatives' social worker. This meant social workers and other social care professionals had visited the service to speak with people, the provider and manager to bring about improvements and to address issues raised. We saw minutes of meetings that had been held which provided an agreed way forward in the support and care of named people.

We found the mechanism for raising concerns and complaints was not understood, as people told us they had not been provided with a copy of the complaints procedure. This meant people were raising concerns in a range of ways, in person, by e-mail and telephone with no clear understanding as to how the information would be considered and what they as the complainant could aspect from the provider and manager in way of a response.

People who had raised concerns confirmed improvements had been made as a result of their concerns, but that changes had taken time to implement and had not always been resolved when the initial concern was raised, which meant people had sometimes raised multiple concerns.

We spoke with the manager about concerns and complaints received and they informed us people were provided with a response; however the procedure for this was not consistently applied. The registered person and manager agreed to take action to ensure people were aware of the complaints procedure and policy, by ensuring the policy and procedure was distributed.

Requires Improvement

Is the service well-led?

Our findings

Care Home

Knighton Manor Limited has not had a registered manager in post for the regulated activity 'accommodation for people who require nursing or personal care' since November 2015. The current manager who had been in post since November 2015 told us of their intention to submit an application to the CQC to be registered.

This is a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

There was a clear management structure in place which included the manager and two deputy managers. The registered person regularly visited the service to meet with staff and those using the service. Meetings involving the management team and senior support workers with the responsibility of guiding and managing support workers took place and were used as an opportunity to reflect on the service being provided. For example, the minutes recorded how a concern was being responded to and how the management team were to monitor the action plan that had been implemented to bring improvements as a response to the issues raised. This evidenced good management and leadership by the use of a collaborative and inclusive approach to bring about improvement.

Strong leadership meant the management team were aware of their responsibilities in ensuring staff received regular supervisions and were provided with the necessary information and guidance. This included changes to policies and procedures which governed how staff worked to ensure people received a quality service based on current guidance. Staff meetings regularly took place and we found meetings were open and inclusive and encouraged staff to share their views about the service being provided.

People using the service spoke positively about the manager and the management team. One person referred to the manager as the boss, stating. "[Person's name is the boss, she's alright, and she sorts problems out."

Staff when asked about the management team and whether they were confidence in the managers, told us. "I'd talk to a senior or manager and I'm confident they would do something." "The team helps each other, the management team will come out (leave the office) and do tasks (provide support to people within the service) on the floor." And, "We get very good support from managers and colleagues, if we have problems there is a team meeting, we are a problem solving team." This further evidenced the commitment by all staff to provide a good quality service to people by working together.

We found that the registered person, manager and staff promoted a positive and open culture which provided a range of opportunities for people and those representing them to comment upon and influence the service provided. In addition to meetings, in which people using the service took part, their views and those of their representatives were regularly sought through a questionnaire. The information gathered from questionnaires was shared with those using the service and identified any areas for improvement. The most

recent report reflected a good level of satisfaction with those living at Knighton Manor Limited.

Questionnaires in some instances contained comments from people's representatives expressing their satisfaction with the service. They included, 'I am very satisfied with the care and attention that [person's name] receives from staff and management. Also he tells us he is very happy to be there. Thank you.' And, 'Delighted with the care my friend receives. All of the staff are so committed to their residents, and it shows. Full marks and sincere thanks.'

The PPR said of the management and approach of staff to the delivery of care and support, "Staff support people's independence. They have good relationships with people who respond positively to staff."

Policies and procedures were displayed so that they were accessible to people using the service, both on notice boards and within people's bedrooms. These had been written using easy read large print, along with pictures and symbols to support people in understanding their content.

We spoke with the manager to find out how they assured themselves of the quality of the service they provided. They shared with us the audits they had undertaken, which reflected a range of topics, which included health and safety, medicines, housekeeping and the auditing of people's records. As a result of these audits improvements had been made to the décor, and a system to delegate specific daily tasks had been introduced to improve the day to day running of the service.

External agencies responsible for commissioning care for some of the people using the service had assessed the service against their outcome criteria reflective of their contract with the provider. The reports showed that the service was meeting their expectations.

Supported Living

Knighton Manor Limited has not had a registered manager in post for the regulated activity 'personal care' since November 2015. The current manager who had been in post since May 2016 told us of their intention to submit an application to the CQC to be registered.

This is a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

People's representatives spoke of a lack of confidence in the registered person and manager. They told us the registered person and manager were not always quick to respond to their concerns. They said meetings to review their relatives packages of care had not always taken place within the timescales that had been stated. People's representatives raised concerns about the transition to the service, and felt in some instances this had been too quick. The manager informed us that the transfer of packages of people's care was in some instances implemented by commissioners. They told us future planned packages of care were now being managed more slowly to ensure people's needs could be met.

The representatives of people using the service informed us that upon their relative accessing a service they had been provided with very limited written documentation about the services to be provided by Knighton Manor Limited. They told us a majority of information had been provided verbally. We found the lack of clarity around the service to be provided and people's expectations had contributed to people's concerns and lack of confidence in the provider and manager.

We shared with the registered person, manager and deputy manager the views of the representatives of some people who used the service. It was acknowledged that improvements were needed and that action

had been taken. To bring about improvement the manager was working with the quality improvement team (QIT) from the local authority, who had put into place an action plan to bring about positive changes as to the quality of care people receive. A representative of the QIT regularly visited the service to meet with the manager to review the progress of the action plan.

The registered person spoke of their plans to bring about changes and improvements to the service. The manager spoke of improving the range of information and communication between people using the service, their representatives and management team.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The provider was in breach of the conditions of registration as they did not have a registered manager to oversee the regulated activities for which they were registered for.